STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	C 04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for Investigation of Complaint IN00088016. Complaint IN00088016-Unsubstantiated due to lack of evidence. This visit was in conjunction with the Post Survey Revisit (PSR) to the investigation of complaint IN00086091 completed on 2-15-11. This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR completed on 2/15/11 to the Recertification and State Licensure survey completed on 1/12/11. This visit was in conjunction with the Post Survey Revisit (PSR) to the investigation of complaint IN00087550 completed on 3/15/11. Survey dates: April 17, 18, 19, and 20, 2011 Facility number: 001201 Provider number: 155506 Aim number: 100380860 Surveyors: Antoinette Krakowski, RN, TC Vicki Manuwal, RN Mary Anne Cilella, RN (April 19 and 20, 2011) Census bed type: SNF/NF: 104 Total: 104 Census payor type: Medicare: 34 Medicaid: 56 Other: 14	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	C 04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Total: 104 Sample: 3 Sanctuary at Holy Cross was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint Number IN00088016. Quality review completed 4-25-11 Cathy Emswiller RN	F 000		